Questions and Answers about C. P. S.

Question: When did the removal of the one-year limitation on surgical services under C.P.S. surgical contracts become effective?

Answer: April 15, 1952.

Question: What significance does the removal of the one-year limitation on surgical care have, for both the physician and the member?

Answer: The removal of this limitation became effective April 15, 1952. Previous to this change a C.P.S. member was allowed listed surgical benefits for one year (from the date of operation) for each condition. In effect, the new ruling provides continual surgical care, if necessary to correct a lesion, for each condition as long as the member retains C.P.S. membership. Thus, complications or sequelae of a condition, occurring more than one year after the original date of operation, will be considered as a C.P.S. liability. The severe case which requires more than one year's care will be covered until care is no longer necessary—not terminated at the end of one year.

Questions of whether maximum care has already been provided or whether the new development is related to prior procedure need no longer concern either the physician or the member. If operation is necessary, listed benefits of C.P.S. surgical contracts will apply, without regard either to the previous one-year limitation or surgical services for the condition which the member may already have received.

Question: In the past, the one-year limitation on surgical services has meant that C.P.S. did not pay for bilateral surgical procedures when more than one year had elapsed since the first of the bilateral procedures was performed and if the basic disease was the same in each case. Will removal of the one-year limitation mean that C.P.S. henceforth will cover bilateral operation?

Answer: Yes. Removal of the one-year limitation means that C.P.S. surgical contracts will cover bilateral surgical procedures, whenever they are performed for such conditions as cataracts, hernia and fibrocystic breast conditions.

Question: Are the time limitations on C.P.S. medical and hospital contracts affected by the removal of the one-year limitation in the surgical contract?

Answer: No. The change in the C.P.S. surgical contract has no effect whatever on medical or hospital contracts.

Question: Please clarify the recent change in the medical-while-hospitalized contract which makes benefits available from the physician's first visit to the hospital, rather than the third visit.

Answer: This change (effective April 15, 1952) will mean: When patients holding medical-while-hospitalized coverage are hospitalized, it will no longer be necessary for the physician to bill the patient for the first and second visits, regardless of the condition requiring hospitalization.

Question: Does the change in the medical-while-hospitalized contract alter the two-visit-deductible medical contract?

Answer: The two-visit-deductible medical contract is not affected. Members holding two-visit-deductible medical coverage will still be responsible for the first two visits.

Question: When and where will physicians be able to see the motion picture which C.P.S. has produced showing internal functions of C.P.S.?

Answer: The film (called "The Doctors' Plan") is completed and is ready for showing to physicians at their county society meetings and hospital staff meetings. C.P.S. will contact these groups throughout the state in order to arrange scheduling of the presentation; or county societies and hospital staffs may initiate the scheduling arrangements by advising C.P.S. of dates which are most suitable. Two prints of the film have been made so it can be shown simultaneously in Northern and Southern California.

Question: I have not requested authority for treatment of a particular veteran, but I wish to write a prescription for his use. How can this be done under the home town care program?

Answer: It is necessary that the physician have a current authorization for treatment of the specific service-connected condition for which he wishes to prescribe. Requests for authorizations of this type may be made by telephone, collect, to the Veterans Administration Authorization Officer in San Francisco, Los Angeles or San Diego, explaining that authorization is desired so that a prescription may be written.

Question: In treating veteran patients, if an appointment for laboratory or x-ray services cannot be made during the authorized period, how do I again make request for these services?

Answer: The physician should request a re-authorization of the laboratory or x-ray procedures, indicating that the services previously authorized could not be performed during the period in which they were authorized.

Question: Can a veteran patient be billed for balance charges if his earnings are over the C.P.S. income ceiling?

Answer: No. The income ceiling is only for members enrolled under the C.P.S. commercial program. Fees paid by the Veterans Administration for authorized services to veteran patients under the Home Town Care Program are payments in full.